

**STATE OF DELAWARE  
WORKPLACE SAFETY PROGRAM QUESTIONNAIRE**

**GENERAL INFORMATION -- TYPE OR PRINT CLEARLY**

Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Person and Title Completing Form: Mr./ Ms./Dr. \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person and Title: Mr./Ms. Dr. \_\_\_\_\_  
(If different than person completing form)

Point of Contact E-mail: \_\_\_\_\_ Point of Contact Cell Phone #: \_\_\_\_\_

No. of Full Time Employees: \_\_\_\_\_ Part time employees: \_\_\_\_\_ Is any off-site work done? \_\_\_\_\_

Type of Business/SIC Code: \_\_\_\_\_

Are you seasonal? \_\_\_\_\_ If yes, please provide the dates you are open for business: \_\_\_\_\_

Describe Operation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List All **Delaware** Locations or Sites Covered By Policy: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any Workers Compensations Claims in the last twelve months? \_\_\_\_\_

**DEPARTMENT USE ONLY**

RENEWAL DATE: \_\_\_\_\_ FILE #: \_\_\_\_\_ # OF YEARS: \_\_\_\_\_ PERCENTAGE: \_\_\_\_\_

INSPECTION DUE DATE: \_\_\_\_\_ CHECK #: \_\_\_\_\_ AMOUNT: \_\_\_\_\_

AMOUNT PAID LAST YEAR: \_\_\_\_\_ LOCATION(S): \_\_\_\_\_ INSPECTION(S): \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# DELAWARE EMPLOYERS' WORKPLACE HEALTH AND SAFETY INCENTIVE PROGRAM

## I. SAFETY PROGRAMS/PHILOSOPHY

1. Do you have a complete safety program with a written policy statement? \_\_\_\_\_  
(please attach a copy of the index; have complete copy available for the inspector)
2. Who is your Safety Director/Coordinator? \_\_\_\_\_
3. Do you have a safety committee? \_\_\_\_\_ How often do you conduct safety meetings? \_\_\_\_\_
4. Do you follow OSHA records keeping procedures? \_\_\_\_\_  
Please have your latest OSHA 300/300A log available.

- |   |     |    |     |
|---|-----|----|-----|
| 5. Do you maintain written programs on the following? | Yes | No | N/A |
| a. Emergency Plan and Fire Prevention Plan            | Yes | No | N/A |
| b. Occupational Noise Program                         | Yes | No | N/A |
| c. Tag/Lockout Program                                | Yes | No | N/A |
| d. Chemical Hazard Communication (MSDS)               | Yes | No | N/A |
| e. Driver/Vehicle Safety                              | Yes | No | N/A |
| f. Industrial Truck Operators' Program                | Yes | No | N/A |
| g. Respiratory Protection Program                     | Yes | No | N/A |
| h. Personal Protective Equipment/Clothing             | Yes | No | N/A |
| i. Lifting/ Back Safety                               | Yes | No | N/A |
| j. Ergonomics   | Yes | No | N/A |
| k. Blood Borne Pathogens                              | Yes | No | N/A |

- |  |     |    |     |
|--|-----|----|-----|
| 6. Do you address the following in written program or employee training? | Yes | No | N/A |
| a. Portable ladders and stairway safety training                         | Yes | No | N/A |
| b. Scaffold Safety   | Yes | No | N/A |
| c. Fall Protection   | Yes | No | N/A |
| d. Cranes/Hoists (material/personnel)                                    | Yes | No | N/A |
| e. Welding and Cutting   | Yes | No | N/A |
| f. Steel Erection  | Yes | No | N/A |
| g. Excavations   | Yes | No | N/A |
| h. Aerial Lifts  | Yes | No | N/A |

7. Which chemicals are commonly used in the workplace?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8. List job titles and job descriptions of your employees:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. Do you use any of the following tools to train your employees on safety? Please circle those that apply:

- |                                   |                      |
|-----------------------------------|----------------------|
| a. On the job supervised training | d. Safety Consultant |
| b. Videos                         | e. Other             |
| c. Safety Seminars                |                      |

10. What actions have you taken within the last 6 to 12 months to enhance a safer work environment?

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**II. SAFETY EQUIPMENT/PROTECTIVE CLOTHING AND EQUIPMENT** **N/A**

This section deals with protective clothing necessary for the job or jobs performed.

1. List Personal Protective Equipment (PPE) for your industry:

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- |  |     |    |
|--|-----|----|
| 2. Does your PPE comply with applicable regulations and guidelines?                    | Yes | No |
| 3. Is clothing designed well and made of proper materials?                             | Yes | No |
| 4. Is clothing cleaned, maintained & inspected on a regular basis?                     | Yes | No |
| 5. How do you enforce the use of PPE? _____  |     |    |
| 6. Do you partially or fully subsidize employees for their protective equipment? _____ |     |    |

**III. EYE PROTECTION** **N/A**

You should complete this section whenever employees are exposed to such hazards as chemical fumes, vapors, splashes, intense heat, molten metals, wood and metal chips, and high dust levels.

- |  |     |    |
|--|-----|----|
| 1. Are safety glasses worn which meet or exceed ANSI standards?  | Yes | No |
| a) Do they have side shields?  | Yes | No |
| b) Are goggles worn when they are needed?  | Yes | No |
| c) Are all glasses regularly cleaned after each use, particularly the goggles?   | Yes | No |
| 2. Are safety shields worn over safety glasses (for protection against chemical splash, glass breakage & severe impact hazards)? | Yes | No |
| 3. Are there eye or eye/face wash stations in areas where chemicals are handled?   | Yes | No |

**IV. HEARING PROTECTION** **N/A**

Complete this section if your business has a DBA level of 85 or more.

- |   |     |    |
|---|-----|----|
| 1. Do you have a hearing conservation program?  | Yes | No |
| a) Do you comply with all OSHA or Delaware state standards where employees are exposed on a regular basis to high noise levels? | Yes | No |
| b) How and when are workplace noise levels monitored? _____   |     |    |
| c) Do you give your employees annual hearing tests, with records maintained?  | Yes | No |
| d) Is proper hearing protection (ear muffs or plugs) furnished and/or required to be worn?                                      | Yes | No |

e) How is this enforced? \_\_\_\_\_

2. How often are employees given rest periods or alternate work away from the noise? \_\_\_\_\_
3. Do you rotate or transfer personnel who show evidence of a significant shift in hearing threshold? Yes No

## V. RESPIRATORY PROTECTION

N/A

This section applies if your business has an exposure to respiratory hazards.

1. Do you have an oxygen deficiency hazard? Yes No
2. Do you have vapor and particulate hazards (dusts, sprays, fumes, mists, fogs, smoke or smog)? Yes No
3. Are employees exposed to any gaseous contaminants? Yes No
4. Are work areas monitored regularly for contaminant levels? Yes No
5. Are respirators required? Yes No
  - a) Are they properly fitted? Yes No
  - b) Are instructions given in proper use? Yes No
  - c) Are they cleaned, inspected and disinfected after each use? Yes No
  - d) Are filters replaced on a regular, routine basis? Yes No

\*\*\* If the answer to any of the above questions 1 through 5 is "yes," do you have a written respirator program in compliance with Federal Regulation 29 CFR 1910.134 ? YES NO \*\*\*

## VI. SKIN PROTECTION

N/A

This section applies if your business manufactures or uses irritation-producing substances.

1. Are employees with a current or prior work history of dermatitis identified and assigned to another job? Yes No
2. For workers working in skin disorder-producing environments:
  - a) Are the least irritating substances provided? Yes No
  - b) Is the process enclosed and separated from the worker? Yes No
  - c) Is there continual good housekeeping, including **immediate cleanup of unavoidable spills**? Yes No
  - d) Is proper protective clothing and equipment worn? Yes No
  - e) Are water-soluble barrier creams used? Yes No
  - f) Are wash-up facilities (including showers in certain work) provided? Yes No

## VII. FIRST AID

1. Are emergency phone numbers posted in prominent places? Yes No
2. Do you keep first aid supplies highly visible, close to employees, inspected and replenished continuously? Yes No
3. Do you have an AED kit on hand? Yes No
4. Who is trained in First Aid/CPR? \_\_\_\_\_ Is training Red Cross approved? Yes No
5. Do you have emergency shower/eyewash facilities? Yes No
6. Do employees work outside? Yes No

## VIII. MEDICAL EVALUATION

Where allowable under State and Federal guidelines:

1. Is the physical exam job-exposure oriented? Yes No
2. Does your examiner check for signs of drug or alcohol abuse? Yes No
3. Are pre-existing conditions noted and documented? Yes No

4. If respirators are worn, how often are pulmonary tests conducted? \_\_\_\_\_
5. In noisy areas, how often is audiometric testing conducted? \_\_\_\_\_
6. Do you encourage your employees to report any symptoms of illness between physical checkups? Yes No

## IX. HOUSEKEEPING AND MAINTENANCE

1. Are any electrical cords strung across walkways? Yes No
  - a) If so, are they properly marked and guarded? Yes No
2. Do you have specific storage areas? Yes No
3. Are any loose floor mats safety-edged? Yes No
4. Any worn or frayed carpet, open carpet seams or curled edges? Yes No
5. Any holes, uncovered drains, protruding nails, splinters, loose boards or projections in floors? Yes No
6. Are there any false floors or platforms used to provide dry standing & walking surfaces? Yes No
7. Are all floors free of debris, lint, dust, oil, grease, paint or spray residue, granular materials, sand, mud, ice or other slippery traction-robbing material? Yes No
8. Is lighting adequate for all operations? Yes No
9. Do you have emergency lighting? Yes No
10. What type of ventilation system do you have? \_\_\_\_\_
11. What type of sprinkler and/or smoke detection system do you have? \_\_\_\_\_
  - a) When was it last tested? \_\_\_\_\_
12. Are all exits clearly marked and unobstructed? Yes No
13. Are there frequent refuse pickups? Yes No

## X. MACHINE GUARDING

N/A

Complete this section only where machinery is in use.

1. List the types of equipment you have on hand:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Do you keep adequate machine guards in place where required? Yes No
3. Do you have only trained individuals operating or repairing machinery? Yes No
4. Do you implement a preventative maintenance program? Yes No
5. Are any defects remedied immediately? Yes No
6. Do you have maintenance employees on site? Yes No
7. If an employee removes a guard or disengages a safety device, what corrective action is taken? \_\_\_\_\_
8. Is the anchoring secure for fixed-location machinery? Yes No

## XI. AUTOMOBILE

N/A

This section applies if you have employees who drive cars or trucks as a regular part of their work; also where employees drive their own cars on company business.

1. Are employees taught how to inspect vehicles/equipment before use? Yes No
2. Do employees required to operate motor vehicles participate in a Defensive Driving Program? Yes No
3. Are scheduling & driving speeds reflective of this? Yes No
4. Are employees required to have CDLs? Yes No
5. Are Motor Vehicle Reports (MVR's) requested on all drivers at regular intervals? Yes No

6. Are MVR's requested on all prospective employees, covering all states in which they have been licensed? Yes No
7. Are employees required to use seatbelts? Yes No
8. Are horns and back up alarms provided and operable on equipment/ vehicles that require them? Yes No
9. How often are driver training and safety meetings held? \_\_\_\_\_
10. What actions are taken in connection with accidents or violations, and have they proven effective? Describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
11. Are there any time pressures inherent in your operations? Yes No  
 If "yes", describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **XII. GENERAL INFORMATION**

1. When did your insurance carrier last conduct an engineering & loss control inspection of your premises and operations. Date: \_\_\_\_\_

2. What worker's compensation recommendations have been made by them?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Have they been complied with? Yes No

4. Has an OSHA inspection ever been done? Yes No

a) If so, were any recommendations made, citations issued; fines or penalties levied? Yes No  
 If "yes", explain.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. What regulatory authorities inspect your operations?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

a) How often? \_\_\_\_\_

Name of person completing this questionnaire: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please visit our website at  
**[www.delawareinsurance.gov](http://www.delawareinsurance.gov)**